IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

DAVID CHERRY, Personal Representative of the ESTATE OF PAMELA CHERRY, DECEASED,

Plaintiff,

vs.

MACON COUNTY HOSPITAL, INC. d/b/a MACON COUNTY GENERAL HOSPITAL and HANNA C. ILIA, M.D.,

Defendants.

Case No. 2:12-cv-00043

**The videotaped deposition of**

**RICHARD M. SOBEL, M.D.**

**September 25 and 30, 2013**

**VOLUME OF I of III**

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## EXHIBITS



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## EXHIBITS
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The videotaped deposition of **RICHARD M. SOBEL, M.D.**, taken pursuant to notice for all purposes, at the Wingate Inn, 7882 Senoia Road, Fairburn, Georgia, September 25, 2013, at 9:51 a.m., at the instance of the Defendants, pursuant to the Federal Rules of Civil Procedure.

All formalities as to caption, notice, statement of appearance, et cetera, are waived. Reading and signing of the deposition transcript by the deponent is not waived. All objections except as to the form of the question are reserved for the hearing.

## APPEARANCES

For the Plaintiff:

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For Defendant Ilia:

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EXHIBIT C

doesn't answer the question, so I have to repeat it, which is why we're here so late, Dr. Sobel.
A. I don't think so.
Q. So let me repeat the question.
Is it your opinion in this case that the EKG machine used on May 30th, 2011, was an old EKG machine?
A. Now, Counselor, you just repeated the very same question you just asked me a minute ago, and you've charged me with keeping us late. Now, that makes no apparent sense when --
Q. What's your answer?
A. I already said no.
Q. You said, "I wouldn't be surprised."
A. And then you asked me that very same question, and I said no.
Q. Okay. So it's not your opinion that it was old?
A. I wouldn't be surprised, but not a degree of medical certainty.
You asked me two questions. Was it my opinion to a reasonable degree of medical certainty. I told you no.
Q. You told me you wouldn't be surprised.
A. No. You asked me the question after I said I wouldn't be surprised. I told you no.



Q. All right.
A. You asked me the question again, and I said I wouldn't be -- I said no. No, it isn't my opinion to a reasonable degree of medical certainty. I don't have the date of the machine. How could I say?
I wouldn't be surprised. I've worked at these hospitals. They don't tend to have the most up-to-date equipment.
Q. But that statement suggests to me that you're suggesting that this was not an up-to-date piece of equipment. Is that your testimony in this case?
A. I don't know.
Q. Great. Did this EKG computer have sensitive algorithms to detect ST depressions, or do you know?
A. I don't know what you mean by "sensitive."
Q. Did it have an algorithm to detect ST depressions of any degree?
A. No, not of any degree. I don't think so. No.
Q. Okay. What is your basis for that testimony?
A. Well, it missed it.
Q. Okay.
A. There are ST depressions that are quite clear that are near a millimeter, so you would presume that the machine was set at greater than a millimeter. Now, how much greater than a millimeter or equal to a



millimeter or whether the machine was unable to read them because of motion or various other factors, I don't know.
Q. And who sets the algorithms?
A. Who loads the algorithms?
Q. Yeah.
A. The manufacturer.
Q. So when those showed up at Macon County General Hospital, their technicians don't open up the EKG machine and adjust or tweak the algorithm settings?
A. That is correct.
Q. All right. Do you know if this EKG computer algorithm had ST depression within its reporting vocabulary?
A. I'm sure it did, within reasonable medical certainty if that's helpful.
Q. What are you normally looking for to detect a lack of good blood flow to the heart on an EKG?
A. A lack of good blood flow to the heart. Wow. That's not a term of art we use.
Q. And I took that question --
A. A lack of good --
Q. -- just so you know, from a question that Dr. Ilia was asked in his deposition.
A. Well, a lack of good blood flow to the heart



would generally indicate a shock state. That's generally not specifically diagnosed electrocardiographically, but it can be. I think you're looking at -- for a different question.
Q. I'm repeating a question that was asked by plaintiff's counsel to Dr. Ilia.
A. I don't know what the question means, a lack of good blood flow. You'd have to ask me a -- I could try to answer the question as I did already, or I can speculate as to what Mr. Kehoe was thinking.
Q. All right. So how would you answer the question if you were going to try to answer the question?
A. Well, again, a lack of good blood flow to the heart would mean a shock state, so you would typically not diagnose that on an EKG per se.
But I believe he was probably asking about electrocardiographic signs of ischemia, and that is broken down into findings that are diagnostic of a STEMI, findings that are diagnostic of ischemia, findings that are consistent with ischemia, findings that are nonspecific, and then a normal EKG. So the EKG is stratified into those groups, generally speaking. There may be some overlap between non -- between nonspecific and consistent with ischemia, and you may

A. They failed.
Q. And is that what we talked about, Number 7 above?
A. Correct.
Q. Have we covered that, all of your opinions with regard to that area?
A. Yes.
Q. Would you agree that in medicine there are legitimate differences of opinion about the standard of care?
A. In general, the standard of care is a consensus, so not routinely so. I mean, you -- certainly in a tort situation you find experts that have diametrically opposed opinions. But in my opinion, the defense experts in this case can be easily refuted.
Q. Well, in general, are you telling me that there are -- there are no legitimate differences of opinion about the standard of care in a case?
A. Not routinely. The standard of care is generally a consensus --
Q. Okay.
A. -- based on literature, based on experience, based on local factors, so -- but whether or not experts disagree, that's a different question.
Q. Isn't it true that there may be more than one



acceptable way to treat a patient medically?
A. Oh, sure. That's a different situation and a different question.
Q. And would you agree with me that nurses and hospital personnel have to use their own medical judgment in determining the appropriate care for a patient?
A. Of course they use medical judgment. It's one of the variables. Obviously, it's just one of the factors.
Q. Do you have an opinion as to whether the triage portion of her care was properly done?
A. Yes.
Q. Okay. And what's your opinion?
A. She obviously should have been put on a chest pain pathway, and her acuity level was a two rather than a three.
Q. You testified the other day about the EKG program, and you're not offering any opinions with regard to the EKG -- EKG program --
A. Any new opinions?
Q. -- are you?
Well, as to whether it was adequate or inadequate?
A. I want to say that we discussed that in detail



already. But we could review it if you like, but don't blame me for being -- prolonging the deposition.
Q. Do you have an opinion with regard to the EKG program?
A. All of the ones I've previously given.
Q. That it was inadequate?
A. Well, yes. It was inadequate to diagnose the electrocardiographic repolarization abnormalities that were consistent with ischemia, yes.
MR. KEHOE: You know she's taking up all your time. We're going into all of these new opinions now. Is that -- is that what we're doing?
Q. (By Ms. Brown) Did you review Dr. Jones's report?
A. I did.
Q. Okay. Do you disagree with any of his opinions with respect to the hospital and the nursing staff?
A. His report gave me a lot of pause. I would have to pull it out to get more specific. I could say by and large I almost uniformly agreed with each and every one of his conclusions except perhaps --
Q. You agreed?
A. Disagreed with his conclusions except perhaps some of the things that he mentioned with respect to the



prehospital care.
Q. Well, would you mind pulling out Dr. Jones's report and tell me what you agree with? Would that be quicker?
A. I don't know. It's probably not going to be quick either way. Okay. It's a fairly lengthy report.
Okay. Well, to try to answer your question, I'd probably start from the back because I think that's where he talked about the prehospital care.
THE WITNESS: I think we lost the air conditioning for a while again. Okay. The lights will be going out soon.
A. All right. "There is conflicting testimony between the family members and documentation by the fire department," et cetera. "Family members state that they administered resuscitative measures. The EMT crew provided no resuscitative measures or that they did so inadequately and failed to document accurately."
Q. (By Ms. Brown) Which page are you on?
A. I -- this is nine.
That is a fair, factual summary of the conflicting testimony and the issue regarding the failure of the EMT crew to apparently provide resuscitative measures on a timely basis. I do agree with that.

contained excerpts."
THE COURT REPORTER: I'm sorry?
THE WITNESS: I'm sorry. I'm trying to go fast.
"ER charts customarily and appropriately contain excerpts from heart monitor strips." I agree. "Rather than the entirety of the strip." I agree. "Primarily because of record volume concerns." I agree.
"Heart monitor machines are generally calibrated to print out any significant detected abnormality." I agree.
(As read:) "The excerpts appearing in Mrs. Cherry's chart are typical and depict no rhythm abnormalities." Wow. Either he's looking at somebody else's record, or he's got heart rhythm strips that nobody else has. That's hard to fathom there. I don't know what he's looking at. He says there are excerpts. There are no excerpts. Correct me if I'm wrong.
Okay. (As read:) "I disagree with any complaint that computerized reading of the EKG as 'abnormal' was conclusive, diagnostic, or indicative of an acute coronary syndrome." Some of these things I actually agree with. This is an EKG which is consistent with ischemia, which is of concern for ischemia, but is not frankly diagnostic of ischemia. In other words,



there are -- to me, it's a 1-millimeter deflection of the ST which raises a lot of concerns. It's not .5, but then again, it's not 6 millimeters. This is not an EKG that is frankly and absolutely diagnostic of ischemia, but this is an EKG that certainly raises concern and may be consistent with ischemia. I think he's missing the point.
Let's see. It certainly was abnormal. There was no question of that. So I disagree.
(As read:) "Computerized EKGs are subject to a proprietary algorithm." I agree were that.
"The GE Mac 1200," I don't have any reason to disagree with that. I don't know what year it was.
"EKG's automated interpretation is typically dependent on the manufacturer's choice of algorithm." That's part of it. Also motion is another part of it, also voltage is another part of it, and she had relatively low voltage.
(As read:) "The automated interpretation does not represent the recognized standard of acceptable practice." I agree that the -- simply the fact that the machine has detected an abnormality doesn't mean it's absolutely correct. The physician needs to review that and read the EKG appropriately. Sometimes the machine is right. Sometimes it's wrong. Sometimes it sees



things that the doctor doesn't see and vice versa.
Okay. (As read:) "Computer EKG makes no reference to any ST depressions." That is true. I agree.
(As read:) "It is not within the acceptable professional standard of care for ER physicians to accept automated interpretations as definitive or accurate." It depends what part of the automated interpretations. eAccess is very good [phonetic]. It's better than a human. The voltage measurements, the interval measurements typically are very good, and they're typically better than the human eye. But when it comes to -- unless you use a magnifying glass, perhaps. But when it comes to repolarization abnormalities, EKG computer algorithms are not necessarily accurate. I do agree with that.
Q. In the paragraph above that --
THE WITNESS: Any chance of turning the air conditioner back on?
Q. (By Ms. Brown) The paragraph above that, we've talked about the role of the nursing staff in --
THE WITNESS: Thank you.
Q. (By Ms. Brown) -- in interpreting the EKGs. And do you want to look through this real quickly, Doctor, and tell me if there's anything else



that you agree with? That might be a little bit quicker.
A. I don't know how else to do it except read it as fast as I can and tell you. That's what I've been doing. I don't know how else to do it. If you have another way, let me know.
Q. Well, if you read it and tell us when you find a statement that you agree with?
A. Oh, okay. You want me to just do it silently the way I -- instead of reading it out loud?
Q. Yeah. That might go a little bit faster.
A. All right. I doubt it, but okay.
(As read:) "A completely normal EKG would be the exception to the rule for most 58-year-old patients." I don't terribly disagree with that. I'm not quite sure what he means by "exception rather than the rule," but yes, 58 years old, you -- and other ages you may see one abnormality or another. I don't disagree with that.
"There are no acute findings," well -- I'm reading to myself.
Serial EKGs were required.
"I disagree with the contention that an EKG can rule out ischemia." I agree with that.
"An EKG can only rule in ischemia, but not